

HEALTH CARE FOR HOMELESS VETERANS (HCHV) PROGRAM

- 1. PURPOSE:** This Veterans Health Administration (VHA) Handbook establishes procedures for the Health Care for Homeless Veterans Program (HCHV) and sets forth national authority for the administration, monitoring, and oversight of HCHV-funded services.
- 2. SUMMARY OF MAJOR CHANGES:** This Handbook clarifies the duties of those assigned responsibilities under the HCHV Program including implementing and monitoring HCHV funded programs nationally.
- 3. RELATED ISSUES:** VHA Handbooks 1160.01, 1162.01, 1162.05, 1162.06, and 1162.07.
- 4. RESPONSIBLE OFFICE:** The Office of the Deputy Under Secretary for Health for Operations and Management, VHA Homeless Programs, and the Health Care for Homeless Veterans Program are responsible for the contents of this Handbook. Questions may be directed to the National Director, VHA Homeless Programs at 202-461-1635.
- 5. RESCISSIONS:** None.
- 6. RECERTIFICATION:** This VHA Handbook is scheduled for re-certification on or before the last working day of May, 2019.

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Under Secretary for Health

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HEALTH CARE FOR HOMELESS VETERANS (HCHV) PROGRAM

1. PURPOSE: This Veterans Health Administration (VHA) Handbook establishes procedures for the Health Care for Homeless Veterans (HCHV) Program and sets forth national guidelines for the administration, monitoring, and oversight of HCHV-funded services. **AUTHORITY:** The HCHV Program is authorized by 38 U.S.C. 2031 and 38 CFR Part 63.

2. BACKGROUND:

a. The foundation of the HCHV program is the provision of outreach services to Veterans who are homeless. The central goal of the HCHV program is to reduce homelessness among Veterans by conducting outreach to those who are the most vulnerable and who are not currently receiving VA services, and then engaging them in treatment and rehabilitation as well as in other VA programs and non-VA community programs that provide prevention and support services. The HCHV program was developed from the original Homeless Chronically Mentally Ill (HCMI) Program, a 6 month pilot project, established February 12, 1987.

b. In recent years, VA's effort to eliminate Veteran homelessness has led to the development of a range of additional programs and initiatives implemented by VHA Central Office, Office of Clinical Operations, Homeless Programs Office. Additionally, programs such as Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) have been expanded to include programmatic components that address the gaps in services for homeless Veterans. Because HCHV programs typically are the first to make contact with homeless Veterans, they frequently serve as the entry point for these services and thus, provide VA a way to outreach, assist, and offer homeless Veterans an "Open Door" to the continuum of VA services.

c. In addition to this core mission, HCHV functions as a mechanism to contract with providers for community-based residential treatment for homeless Veterans.

d. Because the least disruptive and most economically efficient way to end homelessness is to prevent its occurrence, VA has expanded its homeless initiatives to include support services aimed at the prevention of homelessness. Unlike VA's traditional homeless programs, which focus on treatment and rehabilitation of the individual Veteran, prevention services address those Veterans and their families who are at immediate risk for becoming homeless or who have recently become homeless. This group includes Veterans recently released from prison or who are otherwise involved with the criminal justice system. HCHV programs are well positioned to assist these Veterans in accessing the appropriate level of services through other VA programs and non-VA community programs.

e. The HCHV program is vital for providing a gateway to VA and community-based supportive services for eligible Veterans who are homeless. This includes ensuring that chronically homeless Veterans and/or those with serious mental health diagnoses can be placed in community-based programs that provide quality housing and services that meet the needs of these special populations.

3. DEFINITIONS:

a. **Health Care for Homeless Veterans Program.** The Health Care for Homeless Veterans (HCHV) program is an essential and critical part of VHA, providing a gateway to VA and community-based supportive services for eligible Veterans who are homeless. HCHV programs provide outreach services; care, treatment, and rehabilitative services, including case management services; and therapeutic transitional housing assistance under 38 U.S.C. 2032 in conjunction with Work Therapy under 38 U.S.C. 1718. The program uses Contracted Residential Services (see paragraph 5.d.) in community locations to engage homeless Veterans who have been underserved. Many of these Veterans would benefit from mental health and Substance Use Disorder (SUD) treatment but will not avail themselves of these services without the encouragement of outreach workers.

a. **Homeless.** The HCHV Program follows the definition of “homeless” in 38 U.S.C. 2002(1) and section 103(a) of the McKinney-Vento Homeless Assistance Act, 42 U.S.C. 11302(a). ***NOTE: The term “homeless” or “homeless individual” does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a state law.***

b. **Chronically Homeless.** The HCHV program follows the Federal definition of the term “chronically homeless” from section 401 of the McKinney-Vento Homeless Assistance Act, 42 U.S.C. § 11360.

c. **Substance Use Disorder Specialist.** The Substance Use Disorder (SUD) Specialist is a professional with a Masters degree and an independent license, who is responsible for providing expertise on SUDs to the HCHV and HUD-VASH teams, to other providers within the medical facility, and in the community. The SUD Specialist also provides assessments and treatment to certain high-risk, substance-using homeless Veterans.

d. **Homeless Operations Management and Evaluation System.** The Homeless Operations Management and Evaluation System (HOMES) is an online data collection system that tracks homeless Veterans as they move through VA’s Homeless Programs. The system streamlines data collection processes and facilitates communication between VA homeless program staff and leadership on the local, regional, and national levels. By providing a centralized data collection system, HOMES enables VA to efficiently and effectively collect, manage and access homeless Veteran data. Historically, when a Veteran entered a new VA homeless program or episode of care, homeless program staff would re-enter Veteran data into a program-specific system resulting in duplicated data across separate homeless program systems. Further, these systems did not share information about the Veteran and the care received. The HOMES system allows for single entry of Veteran data and satisfies program operations, management, and evaluation requirements. Any entry into the system is available to all homeless staff across all Veteran Integrated Service Networks (VISN). HOMES is designed so that critical data elements are compatible with HUD’s Homeless Management Information System (HMIS), allowing VA and HUD to meet the goals of integrating community and VA data into a single Registry.

e. **Homeless Management Information System.** The Homeless Management Information System (HMIS) is a computerized data collection tool specifically designed to capture client-level information over time on the characteristics and service needs of men, women, and children experiencing homelessness and the services provided to them. HMIS implementations can encompass geographic areas ranging from a single county to an entire state and are administered

locally within the community (Continuum of Care) by one lead agency that is responsible for standards and privacy compliance, as well as HUD reporting and other funder required aggregate reporting.

f. **Community Integration.** Community integration (CI) refers to a person's belonging and full participation in society. CI traditionally has been defined by three main areas: employment or other productive activity, independent living, and social activity.

g. **Community Resource and Referral Centers.** Community Resource and Referral Centers (CRRC) are VA-funded and operated outreach centers that provide outreach and referrals for Veterans who are homeless or at risk of being homeless and enhance community partnerships.

h. **Medical Respite.** Medical respite refers to acute and post-acute medical care provided for homeless persons who are too ill or frail to recover from a physical illness or injury independently, but who are not ill enough to be in a hospital. Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. Medical respite care can be offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. The care can be provided through any one of a number of different models, including a visiting care team (e.g., visiting nurses, rotating teams), an in-house clinical team, and/or in direct consultation with an established care team at a medical facility in such a way that therapeutic care can be provided and a treatment plan can be carried out at the respite facility.

i. **Homeless-Patient Aligned Care Teams.** The Homeless-Patient Aligned Care Teams (H-PACT) provide accessible, coordinated, comprehensive, patient-centered care, and are managed by primary care providers with the active involvement of other clinical and non-clinical staff. H-PACTs are Patient Aligned Care Teams (PACT) specifically for homeless Veterans that serve three purposes:

(1) Provide a setting for first contact health care to engage the homeless Veteran in care while reducing the use of emergency services.

(2) Provide a care setting that provides "one-stop shopping" where health care is integrated with homeless services.

(3) Provide the services necessary to both assist the Veteran in becoming "housing ready" and help reduce recidivism back to homelessness.

k. **Supportive Services for Veteran Families.** The Supportive Services for Veterans Families (SSVF) Program provides supportive services grants to private non-profit organizations and consumer cooperatives to coordinate and provide supportive services to very low-income Veteran families who:

(1) Are residing in permanent housing;

(2) Are homeless and scheduled to become residents of permanent housing within a specified time period; or

(3) After exiting permanent housing within a specified time period, are seeking other housing that is responsive to such very low-income Veteran families' needs and preferences.

l. **Community Homelessness Assessment, Local Education and Network Groups.** The Community Homelessness Assessment, Local Education and Network Groups (CHALENG) program enhances the continuum of care for Veterans experiencing homelessness. Each VA medical facility is required to participate in CHALENG and to collaborate with the community, State and Federal partners and stakeholders, and Veterans Service Organizations (VSO) to identify needs of local Veterans who are homeless. Homeless and formerly homeless Veterans also provide input regarding gaps in services. These needs are then reported through a national survey. The results are reported to the VA Secretary and are used to help guide future Homeless Program priorities and services.

m. **Recovery Model.** The recovery model is centered on the belief that it is possible for homeless Veterans with mental health conditions to re-establish normal roles in the community. The recovery model fully supports community integration and improved quality of life for Veterans who have been diagnosed with a serious mental health condition that impairs their ability to lead meaningful lives. Within this model, psychiatric rehabilitation services are collaborative and encourage the Veteran's self-determination.

n. **Northeast Program Evaluation Center.** The Northeast Program Evaluation Center (NEPEC) conducts program evaluations and national mental health system monitoring with respect to quality, cost, and outcomes of VHA mental health programs generally and of specialized treatment programs for homeless Veterans.

o. **Stand Downs.** Stand Downs are events held by community agencies in partnership with VA in an effort to reach out and provide services to homeless Veterans. Stand Downs are typically 1 to 3 day events. The range of services can include food, shelter, clothing, health screenings, dental services, legal services, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment and SUD treatment. HCHV Program staff may serve as the local VA facility point of contact (POC) for these events. POCs assist in coordinating the involvement of other VA staff members and outlining their roles in supporting Stand Downs.

p. **Operation New Hope.** Operation New Hope (ONH) maintains warehouses that support VA homeless outreach efforts. These warehouses served as the distribution hubs for surplus clothing and materials for Stand Downs.

q. **State.** "State" has the meaning given in 38 U.S.C. 101(20).

r. **Supportive Housing.** Supportive Housing is a combination of housing and services intended as a cost-effective way to help people live more stable, productive lives. Supportive housing is widely believed to work well for those who face the most complex challenges—individuals and families confronted with homelessness and who also have very low incomes and/or serious, persistent health issues. Supportive housing can be coupled with social services

such as job training, life skills training, alcohol and drug abuse programs, community support services, and case management. Supportive housing is intended to be an efficient, pragmatic solution that improves quality of life and, to the extent feasible, reduces the overall cost of care.

s. **Supportive Services.** Supportive Services encompass a range of services that assist an individual in the transition from the streets or shelters into permanent or permanent supportive housing, and that assist persons with living successfully in housing. Examples of supportive services include, but are not limited to: assistance in securing permanent housing; vocational assistance, including mentoring and coaching as well as job placement; income assistance and financial planning; relapse prevention; and social and recreational activities.

t. **Veteran.** A Veteran, for the purpose of HCHV programs, is a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable and is enrolled or eligible for VA health care under 38 CFR 17.36 or 17.37. An eligible veteran must meet the criteria specified in 38 CFR 63.3 to qualify for benefits under the HCHV program.

4. SCOPE:

a. The HCHV Program, a component of VHA Homeless Programs, provides outreach, case management, and HCHV Contracted Residential Services to Veterans who are homeless. The central goal of the HCHV Program is to reduce homelessness among Veterans by conducting outreach to those who are the most vulnerable and engaging them in supportive and rehabilitative services.

b. The HCHV Program works in collaboration with other VA programs (e.g., Veterans Justice Outreach (VJO) program, Healthcare for Reentry Veterans (HCRV) program) and community outreach providers (e.g., 100,000 Homes Campaign, Projects for Assistance in Transition from Homelessness (PATH), HUD Continuums of Care (CoC)).

c. HCHV awards contracts to community-based agencies to provide short-term residential treatment to Veterans who need an immediate housing placement as they seek permanent housing and/or additional care and services. Depending on the provisions outlined in the contract Statement of Work (SOW), HCHV may be responsible for the direct provision of case management and additional care and services. Additional care and services may include, but are not limited to, vocational training and skills development, and mental health and/or SUD counseling, depending on the terms of the contract SOW and the needs of the particular Veteran.

d. The HCHV Program provides VA medical facilities the information necessary to properly inspect, monitor, and submit the required documents to comply with Federal Acquisitions Regulations (FAR).

5. RANGE OF SERVICES: Depending on the provisions outlined in the contract SOW, the elements of HCHV care that might be provided to a homeless Veteran directly by VA or through a contractor may include:

a. Outreach to identify homeless Veterans encountered in encampments, shelters, drop in centers, and other community locations. The intent of outreach is to provide Veterans with

information on resources such as housing assistance, medical and psychiatric inpatient and outpatient treatment programs, other community-based residential programs or social services, and entitlement providers with referral and linkage to indicated services. Encouraging Veterans to participate in the assessment of and engagement with these services is a vital component of outreach. HCHV works to lower barriers and maintain easy access for Veterans to services in VA and the community.

b. Clinical Assessment to provide a determination of the strengths, needs, abilities and preferences of each Veteran.

c. Initiation of case management to plan and coordinate the homeless Veteran's care. In cases where the HCHV program staff responsible for outreach assume additional responsibility for a Veteran's case management, documentation of this transition needs to be reflected in both the medical record and in HOMES. At a minimum, case management services will include the following:

(1) Working toward the rapid placement of the Veteran in a safe, appropriate setting, with an emphasis on utilizing "housing first" approaches wherever possible. Referral will be based on assessment of needs and patient interest in services.

(2) Arranging, coordinating, and/or providing direct clinical services (enrollment, assessment, treatment plan, reassessment, etc.) and support.

(3) Using Recovery Model principles, actively involving the Veteran in treatment planning with specific and individualized goals and objectives utilizing the Mental Health Treatment Suite. Input from other related clinical disciplines (e.g., psychiatry, nursing, vocational rehabilitation) should be included whenever possible. When the Veteran is receiving his or her primary clinical services through another VA provider, the HCHV case manager will actively contribute to that treatment plan.

(4) Refer and provide linkage to VA medical facilities, VA Regional Offices, other Federal agencies and partners (such as the Department of Labor (DOL), HUD, and the Department of Health and Human Services (HHS)), and/or community-based agencies for services necessary to prevent or eradicate homelessness. These services may include but are not limited to: housing placement and counseling services; health care; financial planning and income support; transportation; legal services; child care; entitlements; vocational assistance; education; recreation; and any other needed assistance. The case manager will ensure the availability of mental health and SUD counseling, either through linkage to available resources or directly, if necessary. The case manager will also work with the VA Information Security Officer and Privacy Officer to ensure security and privacy concerns have been met.

(5) Provide crisis management services and monitor psychiatric status and stability.

(6) Intervene, when necessary, and advocate on behalf of the Veteran to fill gaps in the delivery of services. Typically, this includes referrals for transportation assistance, credit problems, and legal issues stemming from child support, fines, and warrants.

(7) Case management responsibility shifts when the Veteran enters another VA Homeless Residential or Case Management Program, such as Grant and Per Diem (GPD) program, Domiciliary Care for Homeless Veterans (DCHV), HUD-VASH, VJO, HCRV, or Compensated Work Therapy/Transitional Residence (CWT/TR). When a Veteran is admitted to a HCHV-funded program, case management duties may be assumed by the contractor or remain with the HCHV case manager. In either case, the Veteran needs to be informed who will be the primary case manager.

d. **HCHV Contracted Residential Services.** These services are funded through HCHV to address the causes and effects of homelessness in a community-based setting that provides direct services in a safe environment that supports recovery and meets the needs of homeless Veterans. Where applicable, every effort must be made to ensure that community-based settings are equipped to provide for the safety and privacy of homeless women Veterans referred for residential services. There are two distinct levels of HCHV Contracted Residential Services, as outlined below:

(1) Contracted Emergency Residential Services (CERS) programs target and prioritize homeless Veterans transitioning from literal street homelessness, Veterans being discharged from institutions, including those in need of medical respite, and Veterans who recently became homeless and require safe and stable living arrangements while they seek permanent housing. CERS Programs, either directly or through linkage with community and other VA services, provide time-limited services such as supporting mental health stabilization, SUD treatment services, enhancement of independent living skills, vocational training, and employment services. Emphasis is placed on referral and placement in permanent housing or longer term residential programs utilizing VA and/or community resources. Lengths of stay in CERS typically range from 30 to 90 days with the option to extend based on clinical need. ***NOTE: CERS programs represent a consolidation of existing HCHV contract residential programs, previously designated as either residential treatment (RT) or emergency housing (EH). Since varying levels of supportive services have been present in both, as noted above, this consolidation reflects the range and flexibility of these services as currently constituted.***

(2) Low Demand Safe Havens (LDSH) are 24-hour staffed transitional residences with private or semi-private accommodations, that target the population of hard-to-reach, chronically homeless Veterans with mental illness and/or substance use problems who require a low-demand environment. The low-demand or non-intrusive environment is designed to re-establish trust and motivate the homeless Veteran to seek needed treatment services and transitional and permanent housing options. Lengths of stay in LDSH programs are typically 6 months with the option to extend based on clinical need.

e. Follow-up Services are provided after HCHV Contracted Residential Services program completion. The HCHV program conducts aftercare services through regular visits and/or telephone contact with Veterans to assist in community integration and prevention of future homeless episodes.

f. Prevention services are made accessible to assist the Veteran at risk for homelessness through referral to SSVF and other programs providing supportive services to enable the Veteran and his/her family to achieve and maintain permanent housing.

6. RESPONSIBILITIES:

a. **VHA Homeless Programs Office.** The VHA Homeless Program Office, HCHV Programs, ensures that:

(1) Funds for HCHV programs are distributed to VA medical facilities expeditiously and in a manner consistent with applicable law and VA regulations.

(2) Guidance, based on relevant laws, rules, regulations, directives, and analysis of collected data, is provided to Veterans Integrated Service Networks (VISN) and VA medical facilities. This ensures that HCHV programs provide quality services in compliance with the law and VA regulations and operate in accordance with applicable Federal, State, and local guidelines.

(3) Appropriate data collection systems are constructed and employed, applicable program metrics are established with targets, and evaluation is conducted followed by technical assistance and corrective action as needed.

b. **Veterans Integrated Service Network Director.** Each Veterans Integrated Service Network (VISN) Director ensures that:

(1) A Network Homeless Coordinator (NHC) is designated.

(2) HCHV programs within his or her VISN are operated in compliance with applicable Federal law and regulations and VHA policy and procedures.

c. **Network Homeless Coordinator.** Each Network Homeless Coordinator (NHC) is responsible for:

(1) Overseeing and monitoring of the HCHV Programs in his or her VISN.

(2) Coordinating VISN-wide HCHV reports, assessments, evaluations, and follow-up actions for implementing VHA policy and procedures.

(3) Ensuring the Notice of Newly Operational HCHV Contract (NNOC) form (see Appendix C), is sent to the National NEPEC and HCHV offices prior to admitting Veterans.

(4) Ensuring that reports of the initial inspection and annual re-inspections of HCHV Contracted Residential Services programs are reviewed and approved by the VA medical facility Director and submitted timely and in the proper format according to this Handbook. NHC will forward a copy of completed inspection packages to the national HCHV office.

(5) Ensuring that any changes to an existing HCHV contract are documented on the Health Care for Homeless Veterans CRS Action Sheet (see Appendix D) and sent to the national NEPEC and HCHV offices.

(6) Reviewing NEPEC results, HOMES reports, VHA Support Service Center (VSSC) and other evaluation data, and assisting HCHV program staff in the development of thresholds, clinical indicators, program monitors, and corrective actions.

(7) Working with HCHV and medical facility Quality and Performance Management staff to develop risk management and reporting systems for HCHV programs.

(8) Reviewing HCHV program critical incidents and initiating appropriate investigation and follow-up activities in collaboration with the medical center.

(9) Providing support, guidance, and advice to HCHV program staff through regular communication, which must include, but is not limited to, regular site visits.

d. **Medical Facility Director.** Each medical facility Director is responsible for:

(1) Ensuring a HCHV Coordinator is designated, and that this designee ensures outreach services are provided by HCHV teams with sufficient resources to support literal street outreach, Stand Down participation, and collaboration with other VA and community-based homeless programs, as well as related health care and social agencies that serve homeless Veterans.

(2) Providing and maintaining oversight of operational HCHV Contracted Residential Services to ensure the programs provide quality services that are in compliance with applicable laws and regulations, and are operating as indicated in the HCHV contract. **NOTE:** *The HCHV Contract Residential Services Inspection requirements are outlined in Appendix B.*

(3) Designating a Contracting Officer Representative (COR) for HCHV Contracted Residential Services and ensuring that the COR completes all VA required training. **NOTE:** *Special care must be taken to avoid conflicts of interest (see paragraph 20).*

(4) Ensuring that initial and yearly inspections of HCHV Contracted Residential Services are completed in a timely manner. Delays in completion of inspections can lead to disruptions in services for homeless Veterans.

(5) Reviewing yearly inspections of HCHV Contracted Residential Services and making a determination for approval of continued payments based on the program meeting requirements and standards set forth in this Handbook.

(6) Ensuring that a plan of correction is established to address deficiencies noted in inspection reports, including reasonable timeframes for correcting deficiencies and procedures for tracking progress.

(7) Forwarding copies of all inspection documents and deficiencies noted to the NHC annually. **NOTE:** *Failure to submit inspections, or not submitting them in the prescribed format, may result in funds being withheld.*

(8) Ensuring that VA medical facility personnel are available for conducting an initial and annual inspection of each community-based program funded under the HCHV program that is operational in the medical facility's catchment area. It is imperative that inspections are performed in a timely manner to ensure the quality and availability of services for homeless Veterans. Inspections must include a team review of the HCHV Contracted Residential Services general operation including, but not limited to:

(a) **Fire and Safety Compliance.** The facility must comply with applicable fire and safety codes.

(b) **Facility Adequacy.** The facility must be adequate to ensure that the services offered by the HCHV Contracted Residential Services meet applicable standards and regulations.

(c) **Clinical Care.** Clinical care must be provided to ensure that the:

1. Care provided to Veterans in HCHV Contracted Residential Services meets the standards prescribed by local codes and is within the framework of professional health care delivery standards, and operational and/or clinical authority.

2. Record keeping and participant files are compliant with HCHV program regulations and VHA Record Control Schedule (RCS) 10-1; and

3. The clinical care being provided is appropriate for the population being served.

(d) **Nutrition.** Food and Nutrition Service must ensure that:

1. Food preparation areas contain suitable space and equipment to store, prepare, and serve food in a safe and sanitary manner.

2. If meals are served as part of the contract, the meals are prepared in a sanitary manner, are nutritionally balanced, varied, and appropriate for the program participants.

3. Ensuring that homeless Veterans have access to nutritional meals three times per day, 7 days per week, as well as nutritious snacks between meals and before bedtime.

(e) **Licensed Pharmacist.** Approving a licensed Pharmacist or designee to ensure that there is safe and secure storage of medications for Veterans participating in the HCHV program according to the contractor's written policies and procedures as reviewed and accepted by the HCHV Coordinator (see paragraph 13).

(f) **Security.** Ensuring that issues pertaining to security and law enforcement are appropriately addressed.

(g) **Staff.** Ensuring that VA medical facility staff have the appropriate backgrounds, education, and experience necessary to review and inspect community-based programs under the preceding categories. ***NOTE: Review 38 CFR 63.15(d) for further information.***

1. **Billing.** Monthly billing for payments must be accurate regarding Veteran eligibility and the number of bed days of care. The medical facility Director must ensure that: The COR reviews the accuracy of the billing, and that invoices are submitted to the Austin Payment Center.

2. The system of billing is standardized to conform to medical facility business practices.

(h) **Data Collection.** Ensuring that program participant data is collected pursuant to program evaluation procedures developed by NEPEC.

(i) **Record-Keeping.** Ensuring that documents related to initial and annual inspections and for records of reimbursement are accurate and maintained at the local facility.

e. **HCHV Coordinator.** Each VA HCHV Coordinator is responsible for:

(1) Providing oversight of the HCHV program as outlined in this Handbook and appropriate law and regulations, and ensuring coordination of HCHV services with other homeless programs at the VA medical facility such as GPD, HUD-VASH, DCHV, VJO, HCRV, SSVF, and CRRCs.

(2) Developing processes for verifying the Veteran status and eligibility of program participants.

(3) Collecting and submitting HCHV program participant data, as outlined by NEPEC, HOMES, and VSSC evaluation procedures. The HCHV Coordinator is expected to work with HCHV clinical staff to encourage timely reporting of HCHV program activity as needed.

(4) Providing oversight of outreach and case management services.

(5) Designating a COR for contract residential services, whose functions include but are not limited to, acquisition planning, contract development and Quality Assurance Surveillance Plan (QASP) monitoring.

(6) Facilitating outreach by disseminating information on VA and community services to encampments, shelters, drop-in centers, and other community locations.

(7) Establishing a process for referrals, screenings, entries, and exits to all CERS for which HCHV provides oversight.

(8) Ensuring that HCHV program staff participate in the local HUD CoC meetings and activities (e.g., Point in Time (PIT) Count, street outreach) and ensure contractors have agreed to participate in HMIS by including this responsibility in the SOW solicitation.

(9) Ensuring that budget, payment, and resource allocations meet all VA standards.

(10) Ensuring that the HCHV program obtains and maintains a third party accreditation with Commission on Accreditation of Rehabilitation Facilities (CARF) and, where indicated, The Joint Commission in accordance with VHA Handbook 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs.

f. **HCHV Program Staff.**

(1) The HCHV program staff may perform any or all of the following functions:

(a) Outreach (see paragraph 8).

(b) Case management (see paragraph 9).

(c) Contract liaison (see paragraph 10.c.).

(2) The following duties may be assigned by the HCHV Coordinator and should be conducted in collaboration with other medical facility Homeless programs and community partners as appropriate:

(a) POC for the National Call Center for Homeless Veterans (NCCHV), responding to Veteran requests for assistance.

(b) POC for Stand Downs, coordinating the involvement of other VA staff members and outlining their roles in supporting Stand Downs.

(c) POC for local Homeless Veteran community partnership meetings (e.g. Summits, CHALENG meetings, etc.).

(d) POC for clinical reminders, responding to referrals and consults as required and outlined by local policy.

(e) Liaison for SSVF programs.

g. **Contracting Officer's Representative.** For the responsibilities of the Contracting Officer's representative, see Appendix A.

7. HCHV PROGRAM TEAMS:

a. The composition of HCHV program teams will vary from site to site, but at a minimum will include individual(s) responsible for HCHV program coordination and outreach. Typically HCHV program coordinators hold Master's degrees in social work, nursing, or psychology, and may or may not directly participate in outreach. Outreach workers usually also have a Master's degree; however, outreach can be conducted by staff who are otherwise trained and prepared (e.g., Peer Specialists) as long as VA requirements regarding clinical supervision and documentation are followed. Many programs utilize a part-time or full-time clerk to assist with data collection, management, and administration.

b. It is important that professionals working in the HCHV program have the freedom and flexibility to move beyond traditional modes of service delivery in order to develop innovative approaches to reach out to and assist homeless Veterans. These non-traditional approaches may include casual dress, irregular tours of duty, and coordination of activities with community agencies. It is expected that outreach be conducted off medical center grounds where homeless Veterans congregate or receive basic services. HCHV program staff must be self-motivated and must be given the autonomy and flexibility to develop innovative programs that identify and engage underserved homeless Veterans.

c. HCHV program staff must develop partnerships with the individual Veteran, other VA staff, and other community providers, HUD CoCs, local non-profit agencies, and State and Federal partners. The success of individual programs depends greatly on the rapport between and collaborative efforts of the HCHV program staff and the community providers. HCHV program staff must have the skills required to provide these functions.

d. The staff selected to work in HCHV programs should have the ability and experience to work with community-based providers and be qualified to provide oversight and case management for program participants.

NOTE: *It is beneficial to include a Veterans Benefits Administration (VBA) representative as an associate member of the team. VBA outreach efforts provide a number of referrals to the HCHV program. A list of VBA Homeless Outreach staff available to address benefit eligibility issues for homeless Veterans can be found at:*

<http://vbaw.vba.va.gov/bl/27/outreach/veterans/homeless/index.htm>. This is an internal VA Web site and not available to the public.

8. OUTREACH: Outreach is a key and essential element of the HCHV program, designed to reduce homelessness among Veterans by directly contacting those who are the most vulnerable and underserved and engaging them in supportive and rehabilitative services. Outreach is an active process, initiated by the program and staff, with the intent of extending assistance in the community.

a. **HCHV Outreach Staff Duties.** The following HCHV duties, which are deemed necessary to provide effective outreach, are intended to be examples and do not represent an exclusive listing; moreover, they are subject to existing medical facility policies, protocols, standards, position descriptions, staffing levels, etc. They include but are not limited to:

(1) Performing community-based outreach activities as directed by the HCHV Coordinator.

(2) Verifying Veterans' eligibility for VA hospital care and medical services.

(a) HCHV programs have initiated procedures enabling the HCHV program staff to complete eligibility applications. HCHV program staff may find it helpful to assist the Veteran in completing other eligibility procedures, such as discharge upgrades, statements in support of benefits claims, etc. This type of practical assistance will help the worker establish rapport and develop trust so that the Veteran will be receptive to available treatment.

(b) Assisting Veterans as needed in completing VA Form 10-10EZ, Application for Medical Benefits, for those Veterans not seen at the medical facility.

(c) HCHV program staff with wireless devices should also be authorized access to check eligibility status (e.g., using Hospital Inquiry (HINQ)).

(d) Because homeless individuals' needs will be urgent, HCHV program staff often tries to expedite verification of Veterans' eligibility status through close working relationships with the medical facility's Administration Eligibility Section and VBA Regional Office staff.

(e) In cases where eligibility is not yet determined and the Veteran is at risk, HCHV program staff needs to make every attempt to arrange for provision of care through VA or community resources. **NOTE:** *Care provided to a Veteran later determined to be ineligible is subject to billing under 38 CFR 17.102.*

(3) Educating Veterans about available resources and providing referrals and linkages for the services homeless Veterans may require or want.

(4) Instilling hope that the homeless Veteran can maintain housing stability and be self-sustaining in the community.

(5) Utilizing, when necessary, a focus on low-demand services that are non-intrusive and are designed to re-establish trust and eventually re-engage the homeless Veteran in needed treatment services such as LDSH and the use of motivational techniques for Veterans in various stages of treatment readiness.

(6) It is critical that HCHV program staff work collaboratively with VA medical facility Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Coordinators and Women Veterans Program Managers to ensure outreach activities for these special populations are coordinated, timely, and adequate to address the local needs of these groups. HCHV program staff work to develop, maintain and expand relationships with service providers in the VA medical facility and community to minimize barriers to services and improve timely access to care while expanding the continuum of care available to Veterans.

(7) Participating in the HCHV program evaluation activities.

b. Documentation.

(1) An initial HCHV outreach service contact indicates the beginning of a service episode and must be documented in Computerized Patient Record System (CPRS) in accordance with local medical center policies and procedures.

(2) At a minimum, outreach services should include a progress note indicating the Veteran's status. Typically, this progress note will document at least one of the following services:

(a) Referral to another level of care either within the homeless program continuum of care or to other medical services within VA or in the community.

(b) Need for, and plans to continue, outreach to complete assessment and referral.

(c) Termination and/or completion of service delivery.

(3) The Veteran's status at the end of the initial episode of care must be documented in HOMES. A Veteran's case file will remain open until and unless a referral is made and accepted by another service provider and is documented in HOMES. For further HOMES documentation instructions for HCHV outreach, see paragraph 23.

9. CASE MANAGEMENT:

a. HCHV case management reflects a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for services to meet the needs of the homeless Veteran.

(1) HCHV case management serves as a means to ensure psychosocial needs are met and to facilitate assistance with appropriate housing placement. Once a homeless Veteran is referred to HCHV as an individual in need of HCHV case management, the case manager works with the homeless Veteran to identify appropriate VA and community-based providers and facilities throughout the continuum of services. Effective HCHV case management requires regular, direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned.

(2) For Veterans in emergency shelters, HCHV program staff will ensure the availability of case management either through VA or community service providers.

b. Assessment and Treatment Planning.

(1) Within the role of case manager, HCHV program staff are responsible for the overall management of Veterans within the HCHV program from initial contact through exit of the Veteran to another program within the homeless continuum of care.

(2) HCHV case managers are not responsible for case management within other programs unless specifically assigned. Treatment plans for each Veteran are a required component in the provision of HCHV case management services to ensure continuity of care, either as an independent plan developed by the HCHV program staff or as an integrated part of an interdisciplinary treatment plan. HCHV case managers are expected to use the Mental Health (MH) Treatment Suite for treatment planning. Treatment objectives are determined in coordination and agreement with the Veteran through use of engagement, assessment, health care, advocacy, education about resources, referral, and supportive counseling.

(3) The treatment plan objectives that are developed by HCHV program staff should be reflected in the Veteran's individualized treatment plan may include but are not limited to:

- (a) Improve the Veteran's safety.
- (b) Assist the Veteran in achieving or returning to mainstream community housing.
- (c) Improve the Veteran's overall physical and mental status and promote a healthy lifestyle.
- (d) Instill hope.
- (e) Increase employability or increase income, or improve income management.
- (f) Improve the Veteran's overall quality of life.
- (g) Improve the Veteran's self-esteem, self-efficacy, and independence.
- (h) Assist the Veteran in achieving an optimal level of psychosocial functioning.
- (i) Provide support services aimed at the prevention of homelessness.

(4) An individualized treatment plan must include specific goals, measurable objectives, targeted dates for completion, a designated responsible individual for addressing each goal, and must be completed in accordance with current accrediting body standards.

(5) The treatment planning process is designed to assist each Veteran in identifying strengths, needs, abilities, and preferences to identify and meet goals. This planning process is done in each HCHV program with the Veteran a full partner in the process.

(6) Timeframes for developing and updating plans are based on accrediting body standards. The Veteran's needs, problems, goals, and action plans are identified utilizing the treatment objectives (see paragraph 9.a.) and information obtained through the assessment process, including direct input from the Veteran and from the Veteran's family or significant others, as available and appropriate. Providers beyond the HCHV program who are currently involved in the Veteran's care need to be included in the planning process.

(7) When HCHV program staffing patterns include multiple clinical disciplines, interdisciplinary treatment team meetings need to be conducted with the Veteran present, as appropriate. Specific target dates need to be identified and monitored. The interdisciplinary team conducts periodic reviews throughout the Veteran's stay, consistent with accrediting body standards. Reviews can also be requested by the Veteran, a team member, or another provider involved in the Veteran's care.

(8) Interdisciplinary meetings that include discussion of medication treatment plans must include consultation from the clinical pharmacist. This includes but is not limited to performing initial and periodic assessment of medication therapy, medication monitoring plans (as appropriate), and identifying patient-specific medication issues, including drug interactions, adverse effects, efficacy, appropriateness, and compliance problems for homeless Veterans.

c. Documentation.

(1) Case management services must be documented in CPRS in accordance with local medical facility policies and procedures.

(2) Entry into case management services should be documented by a progress note indicating the Veteran's entry into HCHV case management.

(3) A clinical assessment and individualized treatment plan must be documented in CPRS in accordance with local medical center policies and procedures and paragraph 9.b.

(4) Referrals for other services within VA or in the community must be documented in CPRS in accordance with local medical facility policies and procedures.

(5) The frequency of recording progress notes must be established by the medical facility in program policies, and be appropriate for both the Veteran populations served and the program objectives. Progress notes must reflect:

(a) The Veteran's progress towards treatment plan goals and objective.

(b) Any barriers to progress and strategies employed.

(c) Any significant events and status change including resolution of problems and program exit.

(6) The Veteran's entry to and referral from HCHV case management must be documented in HOMES. A Veteran's case file will remain open until and unless a referral is made and accepted by another service provider and is so documented in HOMES. For further HOMES documentation instructions for HCHV Case Management, refer to paragraph 23.

10. HCHV CONTRACTED RESIDENTIAL SERVICES:

a. **Eligibility.** To be eligible for HCHV Contracted Residential Services, a Veteran must meet the requirements of 38 U.S.C. 2031(a) and 38 CFR 63.3.

b. **Program Entry.**

(1) Veterans may apply directly to the contracted provider for HCHV Contracted Residential Services or be referred from other programs, both within and outside VHA.

(2) Veterans need to be screened for entry to HCHV Contracted Residential Services to determine medical and psychiatric stability and their suitability for entry to the program.

(3) Since VA and the contracted provider will be working closely together to ensure the safe and effective treatment of each Veteran, it is essential that Veterans permit communication between VA and the contracted provider through an appropriate Release of Information (ROI). Veterans who refuse to allow this communication about their treatment needs and ongoing care will need to receive services elsewhere.

(4) Depending on the terms outlined in the service contract SOW, during the screening process, HCHV program staff will determine eligibility and either the HCHV program staff or the contracted provider will evaluate the suitability and appropriateness of the level of care. When a Veteran is determined to be ineligible or if the level of care is not, the HCHV program staff will collaborate with the Veteran and the contracted provider to make every effort to arrange for provision of care through other VA or community resources.

(5) Each HCHV Coordinator will develop specific policies and procedures guiding the entry process that are consistent with the contract and that minimize access barriers to the program.

(6) Veterans cannot be denied entry to HCHV Contracted Residential Services based solely upon length of current abstinence from alcohol or non-prescribed controlled substances, the number of previous treatment episodes, the time interval since the last program entry, the use of prescribed controlled substances, or legal history. The screening process must consider each of these special circumstances and determine whether the program can meet the individual Veteran's needs while maintaining the program's safety, security, and integrity.

(7) HCHV programs are encouraged to develop contracts that address the needs of special populations including women, OEF/OIF/OND, SMI, and chronically homeless.

c. **HCHV Contract Liaison Functions.**

- (1) Verifying the Veteran status and eligibility of program participants.
- (2) Verifying entry and exit dates of program participants for billing purposes.
- (3) Verifying bed occupancy.
- (4) Ensuring collection and submission of HCHV program participant data as outlined by HOMES procedures.
- (5) Complying with documentation standards in accordance with local medical facility policy.
- (6) Complying with criminal conflict of interest laws and Executive Branch Standards of Conduct to avoid conflicts of interest in carrying out liaison duties. **NOTE:** *Liaisons must avoid being employees, Directors, trustees, general partners, or officers of the grantee(s) for which they have oversight (see paragraph 20).*
- (7) Providing oversight, in collaboration with COR functions, of HCHV-funded program participants' care and, at times, case management of those participants at sites where organizations are receiving HCHV contract funding.
- (8) Linking (e.g., providing direct assistance), when necessary, and referring to VA medical facilities, VA Regional Offices, and/or community agencies.
- (9) Intervening, when necessary, and advocating on behalf of the Veteran to fill gaps in the delivery of services.
- (10) Participating in the inspection process including documentation of compliance with HCHV Contract Residential Services Inspection requirements. **NOTE:** *The HCHV Contract Residential Services Inspection requirements are outlined in Appendix B.*
- (11) Identifying Veterans who are eligible for Homeless Veterans Dental Initiative (HVDI) services and facilitating linkage necessary to coordinate care.
- (12) Extending the length of service (LOS), when appropriate, in consultation with the HCHV coordinator and in compliance with the existing contract provisions. Any changes that would modify the existing contract would need to be referred to the Contracting Officer for action.

d. **Documentation in HCHV Contract Residential Services Programs.** All clinical documentation must be in compliance with local VA medical facility policy and procedures. HCHV program staff must ensure that documentation on all Veterans receiving services through the HCHV Contract Residential Services Program includes the following in the Veterans clinical record in CPRS:

- (1) **Assessment that includes:**
 - (a) History of homelessness;

- (b) Mental health history;
- (c) Physical health history;
- (d) Substance use history;
- (e) Social history;
- (f) Education, vocational and income history;
- (g) Legal history;
- (h) Strengths; and
- (i) Barriers/Vulnerabilities.

(2) Program Entry Note/Initial Treatment or Service Plan that includes:

- (a) Reason for referral (including justification for any re-entries);
- (b) Program to which the Veteran is admitted;
- (c) Pertinent past treatment history;
- (d) Veteran's engagement; and
- (e) Preliminary treatment or service plan.

(3) Treatment Plan. (see paragraph 9.b.)

(4) Progress notes, as clinically indicated and at least one per month, that includes:

- (a) Progress toward the Veteran's goals;
- (b) Veteran's participation in treatment;
- (c) Progress toward goals;
- (d) Summary of service or contact; and
- (e) Changes to treatment or service plan.

(5) Exit/Discharge Note. Veterans who have been in HCHV Contract Residential Services must have a program exit summary upon termination from the program for each episode of care (see paragraph 15). The exit summary must be completed by the HCHV program staff having primary responsibility for treatment of the Veteran. Medical care and services provided, and recommendations for follow-up care, are to be documented in this exit summary, which must include but is not limited to:

- (a) Date of exit;

- (b) Type of exit;
- (c) Veteran's perception of exit and agreement with exit;
- (d) Status of treatment goals at time of exit;
- (e) Aftercare plan;
- (f) Veteran's agreement with aftercare plan; and
- (g) Housing status and contact information.

(6) The Veteran's entry to and referral from HCHV Case Management must be documented in HOMES. A Veteran's case file will remain open until and unless a referral is made and accepted by another service provider and is so documented in HOMES. For further HOMES documentation instructions for HCHV case management, refer to paragraph 23.

11. CONTRACT PROCESS: The Contracting process consists of the following three phases:

a. **Phase 1.** Acquisition Planning involves the local Contracting Officer (CO), the HCHV program manager or designee, and the COR. ***NOTE:** Specific information related to the COR responsibilities pertaining to HCHV contract residential services is found in Appendix A. The activities of acquisition planning are related to technical, cost and schedule requirements including:*

(1) Development of product specifications in line with contract requirements, as reflected in Appendix B, HCHV Community Residential Services Inspection requirements.

(2) Preparation of the SOW according to service specifications.

(3) Identification of Contract Deliverables such as tasks, hardware, software, designs, physical plant, and schedules.

(4) Establishment of a Delivery/Due date schedule.

(5) Establishment of Integrated Product Teams (IPT), Contract Review Boards (CRB), and any other necessary contract-related work groups.

(6) Conducting market research based on review of Internet, trade journals, previous contracts, other government agencies, etc.

(7) Development of the Independent Government Estimate (IGE), a detailed cost estimate for project, services, or goods or supplies.

(8) Justification of sole-source and authorizations, if necessary.

(9) Identifying the funding source(s) and availability of funds.

(10) Establishing evaluation factors to be used as the basis for contract award(s).

(11) Identifying evaluation committee members.

(12) Identifying any government furnished property or equipment (GFP/GFE).

b. **Phase 2.** Contract Formation and Pre-award - Contract Formation involves the local CO, the HCHV program manager or designee, and the COR. The activities of the Pre-award - Contract Formation phase include:

(1) Developing the solicitation and source selection plan (SSP).

(2) Determining the award based on the Market Research Worksheet for Customers that is submitted to NCO (attachment 2 in Acquisition Planning SOP).

(3) Conducting the solicitation review.

(4) Issuing the solicitation.

(5) Evaluating the offers.

(6) Developing the quality assurance surveillance plan (QASP).

(7) Reviewing final contract with the CO.

(8) Signing the COR Delegation Letter.

c. **Phase 3.** Contract Administration, Management or Post-award involves the local CO and the COR. The activities of this phase include:

(1) COR monitoring of contractor performance through the QASP.

(2) Maintenance of COR administrative files to include copies of relevant documents (e.g. COR Checklist, Delegation Letters, Training Certificates, Contracts and Modifications, Inspections, QASP, Past Performance Reviews, etc.).

(3) Inspecting and accepting supplies/services. **NOTE:** *Specific information related to the HCHV Community Residential Services Inspection requirements can be found in Appendix B.*

(4) Establishing terms and conditions.

(5) Processing payments.

(6) Initiating contract modifications and change orders as needed.

(7) Negotiate with CO for contract renewal, closeout, termination, etc.

12. GENDER SPECIFIC CARE PROVISIONS:

a. Special attention needs to be given to meeting the unique treatment needs of homeless women Veterans. These needs often may include assistance with managing sexual trauma, eating disorders, interpersonal violence, and caring for dependents while in treatment.

b. Women Veterans must have access to female clinical staff (whether from the HCHV-contracted provider, VA or other community partner) for additional gender-specific treatment and/or supportive services as needed.

c. HCHV-funded programs maintain and adjust environments to support the safety, security, privacy and services for women Veterans. Special emphasis on privacy and security should be noted in mixed-gender facilities. Veteran residents have a right to be treated with dignity in a humane environment that affords them both reasonable protection from harm and appropriate privacy with regard to their personal needs. The living environments of HCHV Contract Residential Services transitional housing should include:

(1) Residential room and board in an environment that promotes a lifestyle free of sexual discrimination.

(2) An environment conducive to social interaction, supportive of recovery models and the fullest development of the resident's rehabilitative potential regardless of gender or sexual orientation.

(3) Separate and secure bathroom arrangements to ensure an acceptable level of privacy for personal hygiene and grooming.

13. MEDICATION STORAGE AND MONITORING: HCHV Contract Residential Programs are expected to provide appropriate space and security for the storage of medications. This is of particular concern when the setting involves congregate living (multiple unrelated persons within the same residence). HCHV-funded programs that provide transitional housing in congregate living settings should ensure there are appropriate policies and procedures that support the safe storage of medications for Veteran residents. This storage can be provided to the Veteran to secure his or her medications, or central storage can be provided by the HCHV Contract Residential Program.

a. HCHV Contract Residential Programs are expected to have written procedures that address storage while providing access to medications and safe disposal of medications and syringes. Veterans residing in the program should be educated about these procedures and the importance of safely storing their medications.

b. Some Veterans may require medication monitoring, and this should be taken into consideration when developing the contract.

14. TREATMENT PLANNING AND TREATMENT PLANS IN HCHV CONTRACT RESIDENTIAL SERVICES:

a. Individualized treatment plans are developed through a joint effort of the Veteran, the contracted provider, and the HCHV program staff. Treatment plans must be developed for each Veteran based on input from HCHV program staff assessments, other VA clinical data, and the Veteran. HCHV program staff are expected to utilize the MH Treatment Suite for the documentation of treatment plans in CPRS. **NOTE:** *If clinically indicated and if staffing is available, interdisciplinary planning must be provided. HCHV program staff must monitor the*

quality of care provided by the contract facility through regular visits to the facility. Some sites have found it advantageous to have weekly treatment groups to accomplish this goal.

b. Therapeutic and rehabilitative services must be provided by the contracted provider as described in the treatment plan. In some cases, VA may complement the residential treatment facility's program with added treatment services such as participation in VA Outpatient programs (e.g., CWT, Incentive Therapy, Mental Health Clinic, SUD treatment, etc.).

15. EXIT/DISCHARGE FROM CONTRACT RESIDENTIAL SERVICES: Exit or discharge planning for each Veteran starts at the time of admission or entry into the program. Exit planning is for the Veteran to identify personal needs for obtaining housing, continuing recovery, care, treatment, and services after exit. Exit planning is addressed at each interdisciplinary treatment team meeting with the Veteran. LOS is variable based on progress towards goals, objectives, and time frames listed in the treatment plan. The timing of transition to the community is negotiated between the Veteran and the team. Staff are responsible for ensuring that access barriers to continuing outpatient care (e.g., distance, transportation, scheduling) are reduced or eliminated.

a. Veterans may end participation in HCHV Contract Residential Services for any of the following reasons:

(1) The Veteran has accomplished the goals as defined in the treatment plan and is prepared for community integration with identified resources after exit.

(2) The Veteran requires treatment beyond program resources and is to transition to another level of care.

(3) The Veteran has failed to adhere to the rules and the regulations of the program.

(4) The treatment environment does not meet the Veteran's expectations or needs.

(5) The Veteran requests to leave before treatment goals are met.

(6) The Veteran has a personal emergency necessitating exit.

b. There are circumstances when the interdisciplinary team may make a clinical decision to discharge a Veteran prior to program completion. These circumstances include:

(1) The Veteran exhibits dangerous behavior;

(2) The Veteran exhibits a pattern of relapse or unauthorized use of an addictive substance and a lack of engagement in treatment services.

(3) The Veteran refuses to engage in treatment planning.

(4) The Veteran has achieved maximum benefit from treatment in the program.

(5) The Veteran refuses to allow communication between VA and the contracted provider that is necessary to ensure the safe and effective coordination of care.

c. Whether the Veteran ends participation in the program, has completed the program, or is in the process of being discharged by the contract provider, the following will occur:

(1) The Veteran is involved in the exit planning process.

(2) The Veteran is provided clear information regarding exit.

(3) Continuity of VA and non-VA services for medical and mental health needs are arranged. The HCHV program staff is included in decisions regarding the setting and frequency of ongoing treatment and community recovery activities.

(4) Designated staff will follow-up with the Veteran post-discharge to facilitate access to continuing aftercare services.

(5) An assessment of dangerousness and overall mental health stability is made and appropriate action taken, according to the contracted provider's policy.

(6) If the Veteran does not have permanent housing, the contracted provider will provide information that facilitates arrangements for transitional or temporary housing.

(7) The contracted provider will inform HCHV program staff of the Veteran's exit within 24 hours.

d. If a Veteran refuses to participate in exit planning or if a Veteran drops out of treatment without seeing or contacting staff, the contracted provider will notify the HCHV program staff, and assess the level of risk. If the Veteran is deemed to be an immediate danger to him or herself or others, the provider staff should call the Veteran Crisis line (800-273-8255) to assist. If safety concerns persist, local 911 should be called.

e. Appropriate VA and/or community services must be coordinated by the HCHV program staff, as indicated, for aftercare or re-engagement regardless of exit circumstances.

16. WORKLOAD:

a. Workload for HCHV program staff will vary based on a number of factors. Due to the diversity of tasks assigned to HCHV program staff, they may not meet usual office-based mental health clinical workload standards. For example, reported workload will be affected by time spent traveling to outreach sites, attending meetings with community providers, program monitoring and activities as this reduces the time available for clinical care. Travel distances between community outreach locations may also be particularly extensive in rural areas and U.S. territories.

b. HCHV program staff are involved in advocacy, networking, and collaboration with community-based organizations. Functioning on community boards, contacting community agencies, developing resources, and participating in community meetings account for much of what is done in the HCHV program and will account for variations in workload. Labor mapping (see paragraph 16.d.) can be utilized to account for these administrative responsibilities resulting in increased accuracy in workload and productivity reports for HCHV program staff. HCHV Stop Codes are:

Decision Support Service (DSS) Identification (ID) Number	Primary (P) Secondary (S) or Either (E)	DSS ID Name	Definition
508	E	HCHV/ HCMI-Group	Records patient visit for group evaluation, consultation, follow-up, treatment, case management, skills development, etc., provided by VA clinical staff of HCHV programs to homeless Veterans or family members of such Veterans. This stop code is restricted to HCHV programs approved by NEPEC. Includes provider and support services.
528	P	Telephone/ Homeless Chronically Mentally Ill (HCMI)	Records patient consultation or health care management, advice, and/or referral provided by staff funded through the HCHV programs (except for those programs assigned to other specific stop codes, such as the HUD-VASH program) to homeless Veterans with mental and or SUD, or to family members of these Veterans. Provisions of 38 U.S.C. 7332 require that records which reveal the identity, diagnosis, prognosis, or treatment of VA patients that relate to drug abuse, alcoholism, or alcohol abuse, infection with Human Immunodeficiency Virus (HIV), or sickle cell anemia are strictly confidential and may not be released or discussed unless there is a written consent from the individual.

Decision Support Service (DSS) Identification (ID) Number	Primary (P) Secondary (S) or Either (E)	DSS ID Name	Definition
529	E	HCHV/ HCMI	Records patient visit provided by clinical staff of HCHV, except for programs with specific stop codes such as the HUD-VASH Program, to HCMI Veterans with mental and/or SUD or family members of such Veterans. Includes provider and support services. This stop code is restricted to HCHV programs approved by NEPEC. Programs not meeting this requirement should use DSS Identifier 590. Only use 529 in the secondary position when combined with a CWT or Incentive Therapy as the primary code.

c. HCHV stop codes may be paired with those from other programs as directed in specific guidance from those programs. Additional programs utilizing these stop code pairs may include but are not limited to Homeless Veterans Supportive Employment Program (HVSEP) and the Homeless SUD treatment enhancement initiative.

(1) The Homeless SUD treatment enhancement initiative funded HCHV SUD Specialists to provide SUD case management and services to homeless Veterans in the community in an effort to enhance access to care and opportunities for recovery. The end goal is to treat Veterans with SUDs that are serving as obstacles to obtaining and/or maintaining housing. HCHV SUD Specialist Stop Code Pairs are:

Service	Stop Code Pairing	
HCHV	Primary	Secondary
HCHV SUD services provided to an individual at a non-VA location (e.g., at a GPD or HCHV contracted provider, in a Veteran's home, or other non-VA location). Includes but is not limited to outreach, assessment, case management, and treatment provided to an individual or group of homeless or at-risk Veterans.	529	514
HCHV SUD services provided to a group at a non-VA location (e.g., at a GPD or HCHV contracted provider, in a Veteran's home, or other non-VA location). Includes but is not limited to outreach, assessment, case management, and treatment provided to an individual or group of homeless or at-risk Veterans.	508	514

Service	Stop Code Pairing	
	Primary	Secondary
HCHV		
HCHV SUD services provided to an individual at a VA location (e.g., in a VA medical center clinic, VA community-based outpatient clinic (CBOC), VA leased space, or other VA setting).	529	513
HCHV SUD services provided to a group at a VA location (e.g., in a VA medical center clinic, VA CBOC, VA leased space, or other VA setting).	508	560
HCHV SUD services provided by telephone . Includes clinically meaningful telephone contact with homeless or at-risk Veterans.	528	514

(2) The HVSEP Vocational Rehabilitation Specialist (VRS) positions are to be filled by Veterans who were homeless, formerly homeless or at-risk of homelessness, and hired utilizing the Schedule A Non-Competitive Appointing Authority. These VRSs work with the HCHV and CWT programs to provide a variety of community-based vocational services to Veterans enrolled in HCHV to improve employment outcomes. HVSEP Specialist Stop Code Pairing is:

Service	Stop Code Pairing	
	Primary	Secondary
HVSEP		
HVSEP services provided to homeless, at risk of homelessness or formerly homeless Veterans, which include vocational assistance, job development, job placement and ongoing employment supports.	568	529

NOTE: Each site must follow the recommendations of the local Medical Administration Service (MAS) or Health Administration Service (HAS) to ensure that the Veteran's visit is registered as a clinic visit.

d. Labor Mapping for HCHV program staff will vary according to the diversity of tasks performed. An employee working in more than one program area will have his or her time mapped in proportion to the time worked in each area.

(1) Mapping should be reviewed regularly to verify payroll changes made in the employee's assigned VA cost center (VACC), VA Budget Object Code (BOC), and Time & Leave (T&L) Unit, as well as any shift changes or changes in where the employee is working. These changes may require changes in the percentages to the Account Level Budgeter Cost Center (ALBCC) the employee is mapped to. All VHA paid employees must be mapped in the Decision Support System (DSS).

(2) Employee time in the ALBCCs delivering patient care is considered Variable Labor (VL). Time in ALBCCs performing administrative duties is considered Fixed Direct Labor (FDL). HCHV program staff who spend more than 5 hours (in a 40 hour week) performing purely administrative functions (supervision, performance appraisals, non-patient care meetings, COR responsibilities, etc.) directly related to the HCHV program should have the administrative portion of their position split out to FDL in the HCHV program's ALBCC. VL/FDL splits are often used for working supervisors. Activities such as charting, follow-up phone calls, treatment

team meetings, review of laboratory or radiology results, etc. are direct patient care and should be mapped as VL.

(3) Accurate use of VL/FDL splits will result in improved accuracy in productivity reporting for HCHV program staff as time spent on administrative responsibilities will be accurately reported.

Program	DSS Production Unit	ALBCC	DCM Department	Service
Health Care for Homeless Veterans Program (HCHV)	QZ	227QZ1 203QZ1 221QZ1	OQZ1 PQZ1 WQZ1	Psychology Psychiatry Social Work

NOTE: Each site must follow the DSS guidance regarding labor mapping to proper ALBCC usage.

e. In fiscal year 2013, VHA established cost center 8338 for those residential treatment contracts that did not include care as defined by CPT codes and thus could not be paid through the Non-VA Purchased Care system. This cost center would be used with BOC 2560. This BOC refers to services provided through HCHV CRS. This new cost center is listed in VA Financial Policy Volume XIII, Chap 1 Cost Center Appendix, available online at: <http://www.va.gov/finance/policy/pubs/volumeXIII.asp>.

17. ENVIRONMENT AND FACILITIES:

a. **Location.** HCHV program staff usually have office space located in the VA medical facility or CRRC. However, due to the focus on community outreach in the HCHV program, as well as the liaison role with contract agencies, staff may have may have community-based site access as well.

b. **Space and Environment.**

(1) Safe, private space needs to be available for HCHV team members to provide adequate privacy and confidentiality for clinical interviews. In addition, the HCHV program needs to have adequate space for:

- (a) Clerical staff;
- (b) Secure storage of records;
- (c) A conference room for team meetings; and
- (d) An adequate waiting room for homeless Veterans.

(2) Some medical centers have arranged for community-based space for HCHV program teams. These accommodations are best when they allow for safe, private interviews and the secure storage of records and sensitive materials. Access to information technology (IT) equipment is essential.

(3) For the purpose of providing clinical care to Veterans in the community, all HCHV program staff conducting outreach must be provided with wireless devices capable of accessing essential information in the health record.

c. **Personnel Safety.**

(1) **Settings.** HCHV program staff often visit community settings which may present some level of personal risk. Since security personnel are generally not available to mitigate this risk, HCHV program staff are encouraged to use common sense to maintain their safety. For example, HCHV program staff may travel in teams, daylight hours, and carry a minimum of gear. HCHV programs should establish local safety procedures to ensure that the travel plans and whereabouts of HCHV program staff are known by their supervisor and/or designee.

(2) **Safety Training.** Training must be provided to HCHV program staff to enable personnel to identify situations that are likely to result in physical harm, and approaches to use when confronted with a potentially dangerous situation.

(3) **Equipment.** All HCHV program staff performing duties in the community must be provided with a cell phone with texting capabilities as a means to ensure safety. In those areas where cell phone coverage is not available, HCHV program staff will be provided with appropriate training or procedures or alternate equipment to maintain the most effective means of communication available to ensure personal safety. Laptop computers and vehicles must be assigned to HCHV program staff working in the community. Not only are these items necessary for the completion of work, they provide field staff additional security when working outside of the VA facility.

***NOTE:** Before entering into any arrangement or agreement for VA personnel to occupy and use any non-VA space or facilities in connection with the objectives contained in this Handbook, VHA and its contracting personnel should review, and at all times comply with VA Handbook 1820.1, Sharing Use of Space. Questions in that regard should be directed to VA Real Property Service.*

18. LOCAL WRITTEN POLICY AND PROCEDURES:

a. If not included in existing medical facility policies and procedures, local program operating guides must include a mission statement, policies, and procedures, and should be developed and available at all HCHV program sites. These operating guides must meet current accrediting body standards.

b. Such local operating guides should address the following:

(1) Forms and instructions for collecting statistical data for locally determined program evaluation and monitoring, as required by medical center management.

(2) Position descriptions or functional statements, and duties.

(3) Staff transportation and education policies.

(4) Regulations and procedures for psychiatric and medical emergencies.

- (5) Suicide Prevention policies.
 - (6) Staff schedules and outreach sites.
 - (7) Guidelines and procedures for routine medical and psychiatric care referral.
 - (8) End of month reports procedures.
 - (9) Program rules and regulations.
 - (10) Policy for incident reports.
 - (11) Quality and Performance Initiative reports.
 - (12) Policies and procedures relating to confidentiality of patient health records.
 - (13) Staff safety procedures, including those related to equipment and off site communication, for those employees performing duties in the community.
- c. Veterans receiving HCHV case management or HCHV Contracted Residential Services will be provided with a handbook including each of the elements required by CARF and/or accreditation bodies.

19. CONFERENCE CALLS, MEETINGS, AND MINUTES:

- a. All HCHV program staff members are required to attend HCHV program staff meetings, which must be scheduled on a regular basis to address program planning and issues. Quality and performance initiative activities may also be scheduled for these meetings. Staff must also participate in local HUD CoC meetings, if available, to ensure communication between VA homeless programs and community providers. *NOTE: Staff members are encouraged to attend medical facility conferences and community conferences to further develop their clinical skills.*
- b. Treatment meetings must be scheduled on a regular basis, including interdisciplinary clinical staff where applicable and the Veterans, to discuss the Veteran's treatment plan, compliance issues, progress, and exit from the program.
- c. HCHV program staff may be requested to share information with various audiences on the HCHV program. Examples of these activities include presenting the HCHV program to community agencies and providing in-service education to medical center staff and to participants attending VA-sponsored educational programs.
- d. HCHV program staff at each medical facility are strongly encouraged to attend the monthly 1-hour national HCHV conference call. Program policy, trends, and resources, as well as site specific issues and problems are addressed in this open forum and are documented in the minutes of the call, which are posted to the HCHV SharePoint site: <http://vaww.infoshare.va.gov/sites/vhah/HR RTP/HCHV/default.aspx>. *NOTE: This is an internal VA Web site and not available to the public. Periodically, HCHV program sites present information on new program ideas, interesting cases or problem cases, and national program updates during this call.*

e. HCHV program staff may be asked to serve as the CHALENG POC. Even if not designated as the POC, HCHV program staff are expected to take an active role in the CHALENG survey process by soliciting consumer and community participation.

20. CONFLICTS OF INTEREST: In networking with not-for-profit agencies or other community providers, HCHV program staff must be aware of the possibility of situations that could lead to potential conflicts of interest. Staff must periodically review the Standards of Ethical Conduct for Employees of the Executive Branch at 5 C.F.R. Part 2635 and the criminal conflict of interest statutes at 18 U.S.C. 201-209. Staff should direct questions regarding potential conflicts of interest to VA's Office of General Counsel's Ethics Specialty Team at governmentethics@va.gov.

21. RELATIONSHIP WITH VA MEDICAL FACILITIES AND COMMUNITY:

a. **Working in the Community and at the VA Medical Facility.** It is important that the HCHV program be viewed as an integral part of the VA medical care system, as well as the community's network of service providers.

(1) The essence of the HCHV program staff's role in the community is to promote change in attitude regarding the plight of homeless Veterans through interacting with others, sharing information and ideas, and modeling genuine caring and concern for the Veterans served.

(2) One of the many roles of HCHV program staff is that of a facilitator. The goal is to identify the needs of homeless Veterans and bring about change by forming partnerships with community organizations, State and local governments, and other VA programs. These changes may differ from site to site. For instance the role of some HCHV program staff will include:

(a) Educating the community and other VA staff about myths regarding homelessness and those who are homeless or at-risk of homelessness;

(b) Educating Veterans and the community about the services VA provides and the quality of VA services;

(c) Addressing issues concerning Veterans' eligibility for relevant community and/or public assistance and services;

(d) Working with the community to develop therapeutic programs for homeless Veterans; and

(e) Advocating on behalf of the needs of homeless individuals in the community.

b. **Networking with Other Homeless Providers.** To provide the fullest possible range of services, HCHV program staff actively network with VA and community programs and organizations.

(1) Membership and active participation in local community groups, such as Homeless Coalitions, Mental Health Councils, local HUD CoCs, and other homeless service providers are useful. These linkages provide additional sources for referrals and offer alternative resources

that assist VA staff in meeting the needs of the homeless. These organizations may also assist in identification of local needs and resource development. **NOTE:** *Involvement with relevant State agencies and familiarity with national homeless groups will prove beneficial in both locating and developing local resources*

(2) The process of assessing the needs of the homeless population in specific communities and working toward solutions is ongoing. New linkages are constantly being established with the goal of implementing constructive changes. Through the collaborative efforts of VA and community agencies, creative solutions to difficult problems are continually developed and implemented.

(3) HCHV participation in the local HUD CoC is an essential part of HCHV networking activity. HUD CoCs are charged with prioritizing funding and coordinating local services to homeless persons. One of its mandates is to assess the needs of the area's homeless Veteran population and develop plans based upon that assessment. HCHV program staff are in a unique position to contribute to this planning effort. HCHV program staff are strongly encouraged to coordinate outreach activities with HUD CoC outreach teams in order to share resources, knowledge, and awareness regarding homeless Veterans in the local area. These linkages will help to ensure that homeless Veterans who are ineligible for VA health care can be connected to mainstream services available through the HUD CoC.

22. PROGRAM EVALUATION AND DATA COLLECTION:

a. **Northeast Program Evaluation Center.** Congress mandates that VA homeless programs be monitored and evaluated. Northeast Program Evaluation Center (NEPEC) coordinates the program evaluation data collection and is the office primarily responsible for any questions concerning evaluation data collection. Monitoring protocols, manuals and trainings are available to assist in these efforts. **NOTE:** *Questions should be addressed to NEPEC by calling (203) 937-3850. Evaluation materials and reports are available on the NEPEC Intranet Site: <http://vawww.nepec.mentalhealth.va.gov/PHV/description.htm>. This is an internal VA Web site and not available to the public. The monitoring of data helps to:*

- (1) Describe the status and needs of homeless Veterans.
- (2) Monitor services delivered to Veterans in the program.
- (3) Ensure program accountability.
- (4) Identify ways of refining the clinical program.

b. **VHA Support Service Center.** VHA Support Service Center (VSSC) built and maintains a homeless data cube that serves as a repository for homeless program administrative, workload, and outcome data. The cube can serve as an effective management and evaluation tool for HCHV Coordinators and clinical staff. The cube contains data from HOMES, the broader homeless registry, as well as the Patient Treatment File (PTF), and other automated sources of workload and patient data. The cube contains a variety of pre-set reports, as well as hundreds of metrics that can be formed into ad hoc reports by the user. Data in the cube can be analyzed at the national, VISN, VA medical center levels, as well as at the individual patient

level. Training and support in use of the homeless cube are available from VSSC through a help link on the cube itself. The cube can be viewed at the following link:

[http://vawww.fcdm.med.va.gov/pas/en/src/Proclarity.asp?uiConfig=&LibID=%7b4D3EE00A-F481-4BE0-8DB9-996F6887A85C%7d&book=%7b3B976AAC-2BF7-41A6-A5C7-](http://vawww.fcdm.med.va.gov/pas/en/src/Proclarity.asp?uiConfig=&LibID=%7b4D3EE00A-F481-4BE0-8DB9-996F6887A85C%7d&book=%7b3B976AAC-2BF7-41A6-A5C7-723A6CB792E1%7d&showFirstPage=false)

[723A6CB792E1%7d&showFirstPage=false](http://vawww.fcdm.med.va.gov/pas/en/src/Proclarity.asp?uiConfig=&LibID=%7b4D3EE00A-F481-4BE0-8DB9-996F6887A85C%7d&book=%7b3B976AAC-2BF7-41A6-A5C7-723A6CB792E1%7d&showFirstPage=false). *NOTE: This is an internal VA Web site and not available to the public.*

c. **Performance Measurement.**

(1) Various metrics are used to ensure that each program site conforms to the goals of the overall program. Some metrics take the form of formal VHA performance measures, whereas others are internal metrics called critical monitors. Formal performance measures are outlined at the beginning of each fiscal year and can vary from year to year. Other performance measures may be applicable to the HCHV program, and might fall in the category of Quality Indicators, etc. Performance measures are reported by VSSC, which is responsible for maintaining a homeless performance measures report that allows VISNs and VA facilities to review monthly status on key measures, and view patient-level data for validation purposes. Critical monitors are reviewed by NEPEC, and include volume of intakes, number of Veterans served, the presence of mental health and substance use disorders among Veterans seen, and how contact was initiated with Veterans.

(2) NEPEC review of performance of the HCHV program at each medical center is assessed through comparison with other sites, especially with respect to critical monitors. Those sites that differ significantly from others on any particular indicator are identified as outliers. The identification of a site as an outlier will help the coordinator to align the site more closely with the national program. However, sometimes there are reasons for the difference that are related to situations peculiar to a site, and which do not warrant correction. HCHV program coordinators are encouraged to discuss the local program environment and the possible need for changes in operations with NEPEC.

d. **Feedback to Local HCHV Programs.** In addition to an annual progress reports, NEPEC provides sites information about local performance through the national conference call minutes, which are posted on the HCHV SharePoint. Preliminary tables for the progress report are posted on the VHA Intranet. Program Coordinators are required to correct faulty data and to submit any additional information as requested.

e. **Use of Evaluation Data at Local HCHV Program.** Although evaluation forms are developed and analyzed by NEPEC, local HCHV programs often find the information captured through these forms to be useful for clinical and administrative purposes. Many sites use the Assessment Form as a component of the initial psychosocial assessment. Evaluation data are sometimes used in support of quality assurance efforts, student education, and public relations within and outside of the medical center.

f. **Quality and Performance Processes.** Quality assurance and improvement processes are to be carried out in conjunction with, and according to, medical facility Quality and Performance Initiatives Policy.

g. **Accreditation.** HCHV programs are required to be CARF accredited. This independent third-party review is crucial to the quality of VA programs and their perception in both the medical care industry and the community (see VHA Handbook 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs).

23. REPORTING SYSTEM – HOMELESS OPERATIONS MANAGEMENT AND EVALUATION SYSTEM (HOMES):

a. The HOMES system allows for single entry of Veteran data and satisfies program operations, management, and evaluation requirements. Any entry into the system is available to all homeless staff across all VISNs. HOMES is designed so that critical data elements are compatible with HUD's HMIS, allowing VA and HUD to meet the goals of integrating community and VA data into a single Registry. **NOTE:** *HOMES can be accessed online through the site, <https://vaww.homes.va.gov/VAHomes.aspx>. This is an internal VA Web site and not available to the public. HOMES reporting questions should be addressed to NEPEC by calling (203) 937-3850.*

b. **HOMES Episode.** A HOMES episode begins when a full Clinical Assessment Interview is completed and submitted. A HOMES episode closes:

(1) 30 days after the date the last program exit data is submitted;

(2) On the expiration date of the last referral form, if no program entries were documented;
or

(3) 30 days after the full Assessment is submitted if no program referrals were documented.

c. **Documentation.** Data are entered online in HOMES using the following forms and templates to meet reporting requirements:

(1) **Assessment Form.** Clinical Assessment Interview Forms are completed at the time of outreach or on Veterans who are referred to or re-engaging in Homeless Services who do not have an open HOMES episode.

(a) **Pre-Engagement Section.** Pre-Engagement Section is completed when the interviewing clinician conducts a brief needs assessment on a Veteran who has been contacted but may not be willing or able to have a full assessment completed at the time of contact.

(b) **Assessment Interview.** This form requests information regarding the Veteran's background, including military service, current housing situation, employment status, financial benefits, and medical and psychiatric problems. Clinical impressions are documented in the last sections of the Assessment Interview Form. A HOMES episode begins when a full Assessment is submitted.

(2) **Referral Form.** The Referral Form is used to document program referrals to Case Management, Residential Treatment, Services for Justice-Involved Veterans, VA Prevention Services, VA Treatment Services, VBA Services, and Non-VA Services. HCHV program staff or program POCs must respond to all referrals. The outcome of a referral must be documented

by program entry or by declining the pending referral and providing an explanation as to why the Veteran did not receive services.

(3) **Program Entry Form.** Documents program referrals which result in program entry as well as referrals that do not result in program entry.

(4) **Program Exit Form.** Documents program exit, and records exit status concerning the following: housing, employment, clinical problems, and VA and non-VA treatment arrangements.

(5) **End of Episode Status Report.** Documents Veteran's current housing arrangement, housing stability, employment status, and treatment arrangements at the close of the HOMES episode. The end of episode status report is completed by:

- (a) The clinician who submitted the last Exit Form,
- (b) The clinician who submitted the last expired referral, if no program entries were documented, or
- (c) The clinician who submitted the HOMES Assessment if no program referrals were documented.
- d. **Operational Reports.** Operational Reports (e.g., lists of pending referrals, user reports, forms due reports, etc) are available on the HOMES Main Page and should be reviewed.

24. REFERENCES:

- a. 38 U.S.C. 2031.
- b. 38 U.S.C. 2002.
- c. 42 U.S.C. 11302(a).
- d. 38 U.S.C. 2022(a).
- e. 38 CFR 17.33.
- f. 38 CFR Part 63.
- g. VHA Handbook 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs.

RESPONSIBILITIES OF THE CONTRACTING OFFICER'S REPRESENTATIVE (COR)

1. DELEGATION OF COR RESPONSIBILITIES:

a. The COR is designated by the Contracting Officer (CO). This designation shall be in writing, specify the extent of the COR's authority to act on behalf of the CO, identify the limitations of the COR's authority, specify the period covered by the designation, state the authority is not redelegable, and state that the COR may be personally liable for unauthorized acts. See (FAR) 1.602-2(d).

b. The designee must complete 40 hours of COR Training within 6 months of assignment and every 2 years to be designated as a COR by the Contracting Office.

2. CONTRACT PLANNING ACTIVITIES (PRE-AWARD):

a. Collaborates with Health Care for Homeless Veterans Coordinator, HCHV staff, and procurement team during the acquisitions planning phase.

b. Clarifies requirements and develops acquisition plan in accordance with available funding. Participates in the drafting of the Statement of Work e.g. identifying objectives, conducting market research, and specifying compliance criteria).

c. **Evaluates Technical Proposals.**

d. Participates in technical training for potential responders to the Request for Proposal (RFP). *NOTE: Specific duties are detailed in Procurement Process SOP 160-10-01, COTR SOP dated June 25, 2010, and VA Handbook 6500, Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program.*

3. CONTRACT IMPLEMENTATION ACTIVITIES (POST-AWARD):

a. The COR participates in post-award orientation with contractor and Contracting Officer (CO) to review duties and responsibilities.

b. **Inspections.**

(1) Works closely with identified HCHV Contract Residential Services Liaison to ensure that initial and annual inspections are completed in a timely manner and communicated through the HCHV Coordinator and the medical facility Director to the CO.

(2) Ensures that the inspection team appointed by the Director of the medical facility includes representation from each of the required services.

(3) Serves as primary liaison between contractor and CO.

(a) Provides technical assistance to the contractor.

(b) Communicates any recommendations for corrective action following collaboration with HCHV Coordinator to the CO who, in turn, works with contractor on compliance matters.

(c) Manages technical instructions and tasking, including the Quality Assurance Surveillance Plan (QASP).

c. **Ongoing Monitoring Activities.**

(1) Monitors contract performance through utilization of QASP, bed usage, and ongoing communication with identified HCHV Contract Residential Services Program Liaisons using:

(a) Quarterly meetings between COR and CO.

(b) Quarterly reports.

(c) Records performance data in the Contractor Performance Assessment Reporting System (CPARS) (annually and at the end of the performance period).

(2) Possible fiscal responsibilities:

(a) Monitor spending throughout performance period.

(b) Collaborate with Technical Team to ensure responsible use of funds.

(c) May certify invoices for payment using the On-Line Certification System (OLCS).

4. COR ADMINISTRATIVE FILE: The COR is responsible for maintaining a complete administrative file for each active contract in accordance with VA SOP 160-10-01, dated June 25, 2010, and all other pertinent policies and directives including but not limited to: VA Handbook 6500; VA Directive 1663, Health Care Resources Contracting – Buying Title 38 U.S.C. 8153. This file should be maintained in electronic form so it can be easily forwarded to the CO when necessary. This file should include:

a. COR Documentation:

(1) COR Delegation Letter; and

(2) Ongoing Training Certificates.

b. Contracting Documents:

(1) Original Independent Government Cost Estimates (IGCE);

(2) Signed contract;

(3) List of contractor personnel;

(4) Approval memos; and

(5) Modifications.

c. Fiscal Documents:

(1) Funding;

(2) VISTA Obligation Documents;

(3) OLCS payment history;

(4) Invoices; and

(5) Specific evidence of the occupancy of every bed that is billed on a daily basis for the month (e.g., sign-in/sign-out lists, Veteran signatures on rounds, etc).

d. Performance documents and any pertinent security documentation, including:

(1) Performance reviews;

(2) QASP;

(3) QASP reports;

(4) Quarterly COR reports;

(5) Clinical quality assurance report; and

(6) Proof of contractor training (e.g., security, privacy, rules of behavior).

e. Written communications between the Contractor and CO pertaining to the contract (e.g. emails and letters).

5. CLOSE-OUT CORRESPONDENCE: Upon contract closeout, the following information is to be forwarded to the CO for archive disposition in accordance with applicable regulations:

(1) Document a contractor's past performance, indicating any issues or concerns in meeting the contract requirements as specified in the SOW.

(2) Summary of performance using the COTR Questionnaire (at end of each contract term).

(3) Contractor Performance Assessment Reporting System (CPARS) (annually and at the end of the performance period).

**HEALTH CARE FOR HOMELESS VETERANS CONTRACTED PROVIDER INSPECTION
FORM (VA Form 10-10115a)**

VA Form 10-10115a (Health Care for Homeless Veterans Contracted Provider Inspection Form) is available on the VA Forms web site and can be accessed using the following link:

<http://vaww.va.gov/vaforms/>. **NOTE:** *This is an internal VA Web site and not available to the public.*



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May 2, 2014

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APPENDIX C**

**HEALTH CARE FOR HOMELESS VETERANS (HCHV) NOTICE OF NEW CONTRACT
FORM (VA Form 10-10115b)**

VA Form 10-10115b (Health Care for Homeless Veterans (HCHV) Notice of New Contract Form) is available on the VA Forms web site and can be accessed using the following link:

<http://vaww.va.gov/vaforms/>. ***NOTE:** This is an internal VA Web site and not available to the public.*



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**HEALTH CARE FOR HOMELESS VETERANS (HCHV) COMMUNITY RESIDENTIAL
SERVICE (CRS) ACTION SHEET (VA Form 10-10115c)**

VA Form 10-10115c (Health Care for Homeless Veterans CRS Action Sheet) is available on the VA Forms web site and can be accessed using the following link: <http://vaww.va.gov/vaforms/>. **NOTE:** *This is an internal VA Web site and not available to the public.*



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